PERF
INDIANA

Re-Employed Retiree Membership Record and Employer Certification of Eligibility

State Form 50868 (01-10-2002)

PRIVACY NOTICE
All Social Security Numbers are requested by this agency in accordance with the requirements Disclosure is mandatory; this form will not be processed without this information.

INSTRUCTIONS:

1. Please print or type in black ink.
2. The employer must sign to certify that the member meets eligibility requirements.
3. All items on this form must be completed, using "N/A" where not applicable.
4. Please forward the completed form to the Public Employees' Retirement Fund within five (5) days of the member's date of employment.

ENROLLMENT INFORMATION (To be completed by the Employer)

Member Information

Social Security Number	Date of Birth (mm/dd/yyyy)	Date of Application (mm/dd/yyyy)
_ _ _ - _ _ - _ _ _ _	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _

First Name	MI	Last Name

Address

City	State	Zip Code

Home Telephone Number	Other Telephone Number

E-mail Address

GENDER ☐ MALE ☐ FEMALE	CURRENT MARITAL STATUS ☐ SINGLE ☐ MARRIED

Employer Certification

I certify that the individual named in this record is employed in an approved PERF-covered position. I understand that submission of this membership record creates a pension liability on the part of this employer and that employer contributions must begin with the date of hire. I have verified that the Social Security Number on this form is the same as the number used on our payroll and reported to the Internal Revenue Service for tax purposes.

I certify that I am the individual formally authorized to accept said liability for and on behalf of the governing body of this employer, and that the date of employment listed below is correct.

Date Employed (mm/dd/yyyy)	Current Position or Title
_ _ / _ _ / _ _ _ _	

Name of Employer	Employer Account Number

Signature of Authorized Agent	Printed Name of Authorized Agent

Member Name (Last, First Middle Initial)	Social Security Number _ _ _ - _ _ - _ _ _ _

BENEFICIARY INFORMATION (To be completed by the Employee)

Primary Beneficiary or Beneficiaries

Beneficiary Name (Last, First Middle Initial)	Social Security Number or Tax ID	Relationship to Member	
Street Address	City	State	Zip Code
Beneficiary Name (Last, First Middle Initial)	Social Security Number or Tax ID	Relationship to Member	
Street Address	City	State	Zip Code
Beneficiary Name (Last, First Middle Initial)	Social Security Number or Tax ID	Relationship to Member	
Street Address	City	State	Zip Code

Contingent Beneficiary or Beneficiaries

Beneficiary Name (Last, First Middle Initial)	Social Security Number or Tax ID	Relationship to Member	
Street Address	City	State	Zip Code
Beneficiary Name (Last, First Middle Initial)	Social Security Number or Tax ID	Relationship to Member	
Street Address	City	State	Zip Code
Beneficiary Name (Last, First Middle Initial)	Social Security Number or Tax ID	Relationship to Member	
Street Address	City	State	Zip Code

In accordance with the provisions of Indiana Code § 5-10.2-3, I designate my beneficiary or beneficiaries as shown above. If the primary beneficiary or beneficiaries herein designated survive me, they shall receive the funds, if any, that are payable by the fund to a designated beneficiary. If the primary beneficiary or beneficiaries do not survive me then the secondary beneficiary or beneficiaries shall receive such funds. If none survive me, then the beneficiary shall be my estate. If no designation is made, any death benefit due would be payable to my estate. I reserve the right to change the primary or secondary beneficiaries at any time prior to retirement by filing a Change of Beneficiary form with the Board of Trustees of the Fund. Such a change must be received and accepted by the fund prior to my death for it to become effective.

I understand that this designation of beneficiary supersedes and replaces any prior designation of beneficiary that may have been made in the course of this or any prior employment in a PERF-covered position with any other employer.

Signature of Member	Date (mm/dd/yyyy) _ _ / _ _ / _ _ _ _

Member Name (Last, First Middle Initial)	Social Security Number _ _ _ - _ _ - _ _ _ _

PREVIOUS MEMBERSHIP INFORMATION (To be completed by Employee)

Have you previously been employed in a position covered by the Indiana Public Employees' Retirement Fund?		YES		NO
If yes, are you receiving benefits from the Indiana Public Employees' Retirement Fund?		YES		NO
Have you previously been employed in a position covered by the Indiana State Teachers' Retirement Fund?		YES		NO
If yes, are you receiving benefits from the Indiana State Teachers' Retirement Fund?		YES		NO
Have you previously been employed in a position covered by an Indiana retirement fund other than PERF or TRF?		YES		NO

Member Certification

I certify that the information I have provided in this record is, to the best of my knowledge, accurate and complete.

Signature of Member	Date (mm/dd/yyyy) _ _ / _ _ / _ _ _ _